

2-000 MEMBER PARTICIPATION AND ENROLLMENT2-001 MANDATORY MEMBERS AND EXCLUDED CLIENTS

2-001.01 Mandatory Members: The following clients are required to participate as members in Heritage Health (Nebraska's Medicaid managed care program):

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the federal Social Security Act, as amended ("Section 1931"), or related coverage groups.
2. Members who are eligible for Medicaid due to blindness or disability.
3. Members who are sixty-five (65) years of age or older and not members of the blind/disabled population or members of the Section 1931 adult population.
4. Low-income children who are eligible to participate in Medicaid under Title XXI of the federal Social Security Act, as amended (the "Children's Health Insurance Program").
5. Members who are receiving foster care or subsidized adoption assistance under Title IV-E of the federal Social Security Act, as amended; are in foster care; or, are otherwise in an out-of-home placement.
6. Members who participate in a Home and Community-Based Waiver Services program (see Title 480 Nebraska Administrative Code (NAC)). This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and, any other group covered by the State's Section 1915(c) waiver under the federal Social Security Act, as amended.
7. Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 ("Every Woman Matters").
8. Medicaid beneficiaries during a period of retroactive eligibility, when mandatory enrollment for Heritage Health has been determined.
9. Members eligible during a period of presumptive eligibility.

The member's Heritage Health status (mandatory or excluded) is determined by an automated interface between Medicaid's eligibility system and each health plan's system based on information entered on the Medicaid eligibility system known at the time of the interface.

2-001.02 Heritage Health Excluded Populations: The following clients are excluded from Heritage Health:

1. Aliens who are eligible for Medicaid due to an emergency condition only.
2. Clients who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for Home and Community Based Waiver Services.
3. Clients who have received a disenrollment or waiver of enrollment.
4. Clients in the Program for All-Inclusive Care for the Elderly.
5. Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles.

2-001.04 Coverage Rules

2-001.04A Coverage for Excluded Clients: Medicaid coverage for clients excluded from participation in Heritage Health remains on a fee-for-service basis. Excluded clients cannot voluntarily enroll.

2-001.04B Coverage During Enrollment: Due to changes in a member's Medicaid eligibility and/or mandatory for Heritage Health status, a member's enrollment in Heritage Health may periodically change. The health plan(s) is/are responsible for the provision of the services covered by Heritage Health for the member as long as the member is identified as an enrollee of that health plan.

2-002 ENROLLMENT

2-002.01 Purpose of Enrollment Process: Medicaid contracts with an enrollment broker to enroll members who are required to participate in Heritage Health and to initially assign a primary care provider to those members.

The enrollment broker assists members in understanding enrollment requirements and participation in Heritage Health. To facilitate this effort, the health plans are required to have an understanding of the member population and the enrollment process and to assist Medicaid and the enrollment broker in providing adequate information to the members. The health plans are also required to work cooperatively with Medicaid and the enrollment broker to resolve issues relating to member participation and enrollment, and to have the technological capability and resources available to interface with Medicaid's support systems.

2-002.02 Enrollment Activities in the Health Plan: The enrollment broker has the responsibility to enroll a member in a health plan. A member may choose a health plan and primary care provider or the member may be auto-assigned by the enrollment broker to a health plan. A member has ninety (90) days after the effective date of their initial health plan enrollment to choose another plan. Note: Family members may select a different primary care provider and health plan but are encouraged to choose the same health plan.

Enrollment activities must be completed and communicated to Medicaid by the enrollment broker following the date of the notice sent to the member informing the member of the health plan assignment.

The health plan must accept Medicaid members in the order in which they are enrolled through the enrollment broker's system.

The member must have the opportunity to choose the health plan and primary care provider of his or her choice, to the extent possible and appropriate.

2-002.02A Reenrollment: If the member is identified as mandatory for enrollment into Heritage Health within two months of loss of Medicaid eligibility, the member will automatically be enrolled with the previous Heritage Health plan effective the first of the next month possible given system cutoff. Medicaid or the enrollment broker will send the member notification of the re-enrollment.

The member may choose a different health plan only in the following circumstances: (a) if the reenrollment is during the initial ninety (90) day period; (b) during the open enrollment period; or (c) for cause (see Title 482 NAC 2-003.02B) by contacting the enrollment broker and completing a plan transfer request.

2-002.02B Departmental Wards/Foster Care Members: If a member is a departmental ward or foster child the enrollment broker must coordinate enrollment activities with the Child and Family Services specialist responsible for the case management of that member.

2-002.02C Enrollment of an Unborn and Newborn Child: Medicaid will pre-enroll unborns into Heritage Health if the unborn has either a mother or sibling enrolled in Heritage Health. Once Medicaid is notified of a live birth, the newborn will be immediately enrolled in either the mother's health plan or an eligible sibling's health plan. The mother's plan supersedes the sibling's plan, in the event that both mother and sibling are enrolled in Heritage Health. Enrollment changes (i.e., to a different Heritage Health plan) may be made as allowed for any other member participating in Heritage Health. (See Title 482 Nebraska Administrative Code (NAC) 2-003.02.)

2-002.02D Changes in Enrollment Status: A member will be notified by Medicaid or the enrollment if the member's Heritage Health status changes.

2-002.03 Enrollment Rules: The member or the member's legal representative must complete the enrollment process. For purposes of completing the enrollment process, the following rules apply:

1. A friend or relative of the member, who does not have legal authority, may complete the informational portion of the enrollment process if the individual is determined to have sufficient knowledge of the client's health status;
2. The member or his/her legal representative (i.e., guardian, conservator, or Durable Power of Attorney (if the Durable Power of Attorney has this level of authority) must make the choice of the health plan and primary care provider; and

3. The Child and Family Services specialist or designee must act on a Department ward's behalf. The child's foster parents must be involved in the selection of the health plan and primary care provider.

A health plan must not have any direct contact with the member or the member's legal representative, family, or friends prior to the client becoming enrolled with that health plan, unless the contact is initiated by the enrollment broker.

2-002.04 Effective Date of Heritage Health Coverage: The effective date of Heritage Health coverage is the first calendar day of the month of the Heritage Health enrollment. The date of enrollment in a health plan should match the Medicaid eligibility date. This date may occur up to three (3) months prior to the date of enrollment. The health plan is responsible for benefits and services in the core benefits package from and including the effective date of an enrolled member's Medicaid eligibility. The health plan must reimburse a provider for appropriate covered services and that provider must reimburse a member for any payments made by the member.

Exception: Hospitalization at the time of enrollment (see Title 482 NAC 2-002.04D).

2-002.04A Services before Enrollment Heritage Health: Medicaid-coverable services received before the month of Heritage Health coverage becomes effective will be paid on a fee-for-service basis under the rules and regulations of Medicaid Title 471 Nebraska Administrative Code.

2-002.04B Notification of Heritage Health Coverage: The member or the member's legal representative will be notified of Heritage Health coverage.

The member's status must be verified by the medical provider through:

1. Medicaid's Internet Access for Enrolled Providers;
2. The Nebraska Medicaid Eligibility System;
3. The Medicaid Inquiry Line; or
4. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).

Through the enrollment broker functions, and written materials and notice, the member will be kept informed of his or her right to change health plans and/or primary care provider through the enrollment broker functions, written materials, and notice.

If the member does not voluntarily enroll, the enrollment report will not list a primary care provider. The health plan is responsible for the assignment of the primary care provider for members who do not voluntarily enroll.

The health plan is responsible for providing the services in the core benefits package to members listed on the enrollment report generated for the month of enrollment. Any discrepancies between the member notification and the enrollment

report must be reported to Medicaid for resolution. The health plan must continue to provide and authorize services until the discrepancy is resolved.

In case of a discrepancy, the eligibility and enrollment databases used to build the enrollment file serves as the official source of validation. Once the cause for the

discrepancy is identified, Medicaid will work cooperatively with the health plan to identify responsibility for the member's services until the cause for the discrepancy is corrected.

2-002.04C Continuity of Care Period: Within the first month of enrollment, the health plan is responsible for providing each member general information about Heritage Health and the health plan, e.g., member handbook, etc.

The health plan must continue all services that have been authorized by Medicaid fee-for-service prior to the member becoming enrolled in Heritage Health. These services must be continued until the health plan determines that the service no longer meets the definition of medical necessity.

2-002.04D Hospitalization: When a Medicaid client is in an acute care medical or rehabilitation facility prior to the client's enrollment in managed care, Medicaid fee-for-service remains responsible for the hospitalization until the client is discharged from the facility or transferred to a lower level of care. In the event that a client is admitted as an inpatient in an acute care medical or rehabilitation facility and is assigned to a health plan in the same month, the health plan is responsible for that hospitalization.

2-002.05 Automatic Assignment for Heritage Health: If a choice of Heritage Health plan is not made at the of time of application, the member will be automatically assigned to a health plan based on criteria established by Medicaid.

2-003 HERITAGE HEALTH DISENROLLMENT OR TRANSFERS: Disenrollment for the purposes of this section is a change in a member's enrollment from one health plan to another.

A transfer is a change in a member's assignment from one primary care provider to another primary care provider.

A disenrollment/transfer may be made at the member's request (Title 482 NAC 2-003.01) or at the primary care provider and/or health plan's request (Title 482 NAC 2-003.03). A transfer may also be made because the member requires an interim primary care provider (Title 482 NAC 2-003.03E).

2-003.01 Member Transfer Requests: The member must contact the health plan to request a primary care provider transfer. A member may request a transfer from one primary care provider to another primary care provider at any time.

The health plan must assist the member in selecting a new primary care provider by:

1. Discussing the reasons for transfer with the member and attempting to resolve any conflicts when in the member's best interest;
2. Reviewing the member's needs to facilitate the member's choice of primary care provider;
3. Processing the member request; and
4. Notifying Medicaid of the primary care provider transfer via the primary care provider transfer file. The primary care provider transfer will be updated on the member's managed care file.

If a member is requesting a primary care provider transfer, the health plan should carefully document the reason. Any transfer for a member under a "restricted services" provision must be completed per "restricted services" procedures (see 482-000-7).

2-003.02 Member Disenrollment Requests: A member may request a change from one Heritage Health plan to another by contacting the enrollment broker as follows:

1. With cause, at any time;
2. During the ninety (90) days following the date of the member's initial enrollment with the health plan, or the date Medicaid sends the member's notice of enrollment, whichever is later;
3. During the designated open enrollment period;
4. Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
5. If Medicaid imposes the Medicaid established intermediate sanctions on the health plan.

2-003.02A Cause for Disenrollment: The following are cause for disenrollment:

1. The health plan does not, because of moral or religious objections, cover the service the member seeks;
2. The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or
3. Other reasons, including but not limited to, poor quality of care, lack of access to providers experienced in dealing with the member's health care needs or lack of access to services covered under the contract.
4. Medicaid and Health Plan Contract Termination

The effective date of the plan transfer will be the first day of the month following the month of the approval determination.

2-003.02B Determination of Disenrollment for Cause: When the member disenrollment request is for cause, the enrollment broker must complete a "Plan Disenrollment Member Request Form," with the member and forward the request to Medicaid staff for a decision. Medicaid staff will take action to approve or deny the request based on the following:

1. Reasons cited in the request;
2. Information provided by the Heritage Health plan at Medicaid's request; and
3. Any of the reasons cited in Title 482 Nebraska Administrative Code (NAC) 2-003.02A.

Medicaid will take action to approve or deny the request within sixty (60) calendar days of receipt of the request. If the request is approved, the effective date of the plan transfer will be the first day of the month following the month of the approval determination. If Medicaid staff fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

Medicaid staff will process the disenrollment. A notice will be issued to the member or his or her legal representative when the disenrollment is completed. The health plan will be notified via the enrollment report.

The health plan may work with the enrollment broker to resolve any issues raised by the member at the time of request for disenrollment but may not coerce or entice the member to remain with them as a member.

2-003.02C Enrollment Broker Responsibilities: The enrollment broker must also discuss with the member when processing a disenrollment request the following:

1. The importance of maintaining a medical home;
2. How the member's medical care may be affected by the transfer and what the member's responsibility is in obtaining new referrals or authorizations;
3. That outstanding services may require additional referrals/authorizations in order to maintain the continuation of medical care; and
4. That services approved or authorized by one primary care provider and/or health plan is no guarantee of approval or authorization of the same services with the new primary care provider and/or health plan.

Any disenrollment for a member under a "restricted services" provision must be completed per "restricted services" procedures (see 482-000-7).

2-003.03 Primary Care Provider Transfer Requests: The primary care provider may request that the member be transferred to another primary care provider, based on the following situations:

1. The primary care provider has sufficient documentation to establish that the member's condition or illness would be better treated by another primary care provider;
2. The primary care provider has sufficient documentation to establish that the member/provider relationship is not mutually acceptable, e.g., the member is

uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.;

3. The individual provider retired, left the practice, died, etc.; or

4. Travel distance substantially limits the member's ability to follow through the primary care provider services/referrals.

The primary care provider must maintain responsibility for providing the services in the core benefits package to the member until a transfer is completed.

The health plan must assist its primary care providers and specialists in their efforts to provide reasonable accommodations, e.g., provide additional funding and support to obtain the services of consultative physicians, etc., for members with special needs.

2-003.03A Procedure for Primary Care Provider Transfer Requests: The following procedure applies when a primary care provider requests a transfer:

1. The primary care provider must contact the health plan for which the member is enrolled and provide documentation of the reason(s) for the transfer. The health plan is responsible for investigating and documenting the reason for the request. Where possible, the health plan must provide the primary care provider with assistance to try to maintain the medical home;
2. The health plan must review the documentation and conduct any additional inquiry to clearly establish the reason(s) for transfer;
3. The health plan must submit the request to Medicaid for approval within ten (10) working days of the request;
4. If a primary care provider transfer is approved, the health plan will contact the and assist the member in choosing a new primary care provider;
5. If the member does not select a primary care provider within fifteen (15) calendar days after the decision, the health plan will automatically assign a primary care provider; and
6. The health plan must enter the approved transfer of primary care provider on the primary care provider file for the information to be reflected in the managed care system.

The criteria for terminating a member from a practice must not be more restrictive than the primary care provider's general office policy regarding terminations for non-Medicaid members.

The health plan must provide documentation to Medicaid prior to submitting the primary care provider transfer request that attempts were made to resolve the primary care provider member issues (see 482-000-3 Health Plan Disenrollment/Primary Care Provider Transfer Procedure Guide).

2-003.03B Interim Primary Care Provider Assignment: The health plan will be responsible for assigning an interim primary care provider in the following situations:

1. The primary care provider has terminated his or her participation with the health plan, e.g., primary care provider retires, leaves practice, dies, no longer participates in Heritage Health;
2. The primary care provider is still participating with the health plan but is not participating at a specific location and the member requests a new primary care provider (i.e., change in location only); or
3. A primary care provider or health plan initiated transfer has been approved (see Title 482 Nebraska Administrative Code (NAC) 2-003.03A) but the member does not select a new primary care provider.

The health plan must immediately notify the member, by mail or by telephone, that the member is being temporarily assigned to another primary care provider within the same health plan and that the new primary care provider will be responsible for meeting the member's health care needs until a transfer can be completed.

2-003.04 Heritage Health Disenrollment Requests: The health plan may request that the member be disenrolled from the plan and re-enrolled in another plan, based on the following situations:

1. The health plan has sufficient documentation to establish that the member's condition or illness would be better treated by another health plan; or
2. The health plan has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the member.

The health plan must provide documentation showing attempts were made to resolve the reason for the disenrollment request through contact with the member or his or her legal representative, the primary care provider, or other appropriate sources.

The health plan must maintain responsibility for providing the services in the core benefits package to the member until a disenrollment is completed.

The health plan is prohibited from requesting disenrollment because of a change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs.

2-003.04A Procedure for Health Plan Disenrollment Requests: The following procedure applies when the health plan requests a member disenrollment:

1. The health plan for which the member is enrolled must provide documentation to Medicaid which clearly establishes the reason(s) for the disenrollment request;
2. The health plan must submit the request to Medicaid;
3. The health plan must send notification of the disenrollment request to the member at the same time the request is made to Medicaid. The member notification must include the member's grievance and appeal rights;

4. The member, primary care provider and health plan are notified of the approval or denial of the disenrollment request and information will be made available electronically; and
5. If approved, the disenrollment will become effective the first day of the following month, given system cut-off.

2-003.05 Hospitalization During Transfer: When a member is hospitalized as an inpatient for acute or rehabilitation services on the first day of the month a transfer to another health plan is effective, the health plan which admitted the member to the hospital is responsible for the member (i.e., hospitalization and the related services in the core benefits package) until an appropriate discharge from the hospital or for sixty days, whichever is earlier. The health plan the member is transferring to is responsible for the member (i.e., hospitalization and the related services in the core benefits package) beginning the day of discharge or on the sixty-first (61st) day of hospitalization following the transfer, whichever is earlier. The health plan must work cooperatively with the enrollment broker and Medicaid to coordinate the member's transfer.

2-004 WAIVER OF ENROLLEMENT: Waiver of enrollment is the determination by Medicaid that a client is not mandatory for Heritage Health.

2-004.01 Waiver of Enrollment Due to Eligibility Changes: Waiver of enrollment will occur in the following situations:

1. The member's Medicaid case is closed or suspended; or
2. The member is no longer mandatory for Heritage Health (see Title 482 Nebraska Administrative Code (NAC) 2-001.02 and 2-001.03).

Medicaid will notify member and the health plans of the waiver of enrollment. Waiver of enrollment is prospective and is effective the first of the next month.

2-004.01A Hospitalization-Related Waivers of Enrollment: Waiver of enrollment from Heritage Health will occur automatically in the following situations due to a change in mandatory status for Heritage Health.

If the member is receiving inpatient hospital services at the time of waiver, the following rules apply:

1. Waiver of enrollment due to loss of Medicaid eligibility: When a Heritage Health member is receiving inpatient acute or rehabilitation hospital services on the first day of a month that the member is no longer eligible for Medicaid benefits, the health plan is not responsible for services effective the first day of the month the member is no longer Medicaid eligible.
2. Waiver of enrollment due to eligibility category change: When a Heritage Health member is receiving inpatient for acute hospital services and has enrollment waived from Heritage Health due to an eligibility status change, e.g., the member is no longer in a mandatory group for Heritage Health participation, the health plan is responsible for the hospitalization and services provided in the core benefits package until waiver of enrollment occurs.

2-004.02 (Reserved)

2-004.03 Admission to Nursing Facility Care: Admission to a nursing facility may affect the member's enrollment in Heritage Health. The following rules apply:

1. When a member is admitted to a nursing facility, the health plan must determine if the level of care the member requires is skilled/rehabilitative using Medicare's definition of skilled care.
When the level of care the member requires is skilled/rehabilitative, the physical health plan is responsible for payment of services for the member while receiving skilled level of care services.
2. When the member is admitted to a nursing facility for custodial care (i.e., long term care), Medicaid fee-for-service will assume financial responsibility for the facility charges beginning on the date the custodial level of care determination is made. Payment for all services included in the core benefits package will be the responsibility of the health plan.
3. When the member is admitted to a nursing facility for custodial care and the member's primary care provider does not see patients at the facility, the health plan must work cooperatively with the member and the nursing facility to locate a primary care provider for the member. The health plan must make arrangements to ensure reimbursement of primary care provider services provided by the member's nursing facility physician, for referrals, and for all services included in the core benefits package.

For purposes of Heritage Health, skilled nursing services are those nursing facility services provided to eligible members which are skilled/rehabilitative in nature as defined by Medicare and the nursing facility admission is expected to be short term. Custodial services are those nursing facility services as defined in Title 471 Nebraska Administrative Code (NAC) and the nursing facility admission is expected to be of long term or permanent duration.

2-000 CLIENT PARTICIPATION AND ENROLLMENT

2-001 MANDATORY AND EXCLUDED CLIENTS

2-001.01 Mandatory for Managed Care: The following Medicaid-eligible clients are required to participate in Managed Care unless excluded:

1. Clients participating in Children's Medical, pregnant women and parents/caretaker relatives;
2. Clients participating in Children's Health Insurance Programs (CHIP, previously known as Kids Connection) (see Title 477 NAC);
3. Clients participating in the Aid to Aged, Blind, and Disabled Program Grant/Medical (see Title 477 NAC); and
4. Clients participating in the Child Welfare Payments and Medical Services Program (i.e., IV-E, Non-IV-E, Former Wards, Subsidized Guardianship cases) (see Title 477).

The client's managed care status (mandatory or excluded) is determined by an automated interface between Medicaid's eligibility system and the Managed Care system, and is based on information entered on the Medicaid eligibility system, and known at the time of the interface. Clients mandatory for managed care cannot voluntarily waive enrollment unless excluded under 482 NAC 2-001.02 or 2-001.03.

2-001.02 Excluded Clients for Behavioral Health: The following clients are excluded from Behavioral Health Managed Care (based on the information known to the DHHS eligibility system):

1. Clients for the period of retroactive Medicaid eligibility;
2. Aliens who are eligible for Medicaid for an emergency condition only (see Title 477 NAC);
3. Medicaid clients who have excess income or who are designated to have a Premium Due;
4. Medicaid clients eligible during the period of presumptive eligibility;
5. Participants in an approved Program for All-inclusive Care for the Elderly (PACE) program;
6. Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles; and
7. Unborn children of otherwise ineligible pregnant women.

2-001.03 Excluded Clients for Physical Health: The following clients are excluded from Physical Health Managed Care (based on the information known to the DHHS eligibility system):

1. Medicaid clients who have Medicare;
2. Medicaid clients who reside in Nursing Facilities (NF) at custodial levels of care or in Intermediate Care Facilities for Intellectually Disabled (ICF/ID) or in Psychiatric Residential Treatment Facilities (PRTF) (see 471 NAC 12, 471 NAC 31, 471 NAC 32, and 482 NAC 2-004.04);

3. ~~Medicaid clients who participate in a Home and Community Based Waiver (HCBS). This includes adults with mental retardation or related conditions, aged persons or adults or children with disabilities (AD waiver), children with mental retardation and their families, clients receiving Developmental Disability Targeted Case Management Services, adults with traumatic brain injury (TBI waiver), and any other group for whom the State has received approval of the 1915 (c) waiver of the Social Security Act;~~
4. ~~Clients for the period of retroactive Medicaid eligibility;~~
5. ~~Clients residing out-of-state or those who are considered to be out-of-state (i.e., children who are placed with relatives out-of-state, and who are designated as such by DHHS personnel);~~
6. ~~Aliens who are eligible for Medicaid for an emergency condition only (see Title 477 NAC);~~
7. ~~Clients who have excess income (i.e., spend-down met or unmet) or who are designated to have a premium due;~~
8. ~~Clients eligible during a period of presumptive eligibility (see 471 NAC 28-00);~~
9. ~~Organ transplant recipients from the day of transplant forward (see 471 NAC 10-000 and 482 NAC 2-004);~~
10. ~~Clients who have received a disenrollment/waiver of enrollment (see 482 NAC 2-004);~~
11. ~~Clients who are participating in the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters Program);~~
12. ~~Clients receiving Medicaid Hospice Services;~~
13. ~~Individuals who are patients in Institutions of Mental Disease (IMD) who are between the ages 21-64;~~
14. ~~Clients participating in the Subsidized Adoption Program, including those who receive a maintenance subsidy from another state (see 477 NAC);~~
15. ~~Participants in an approved Program for All-inclusive Care for the Elderly (PACE) program; and~~
16. ~~Unborn children of otherwise ineligible pregnant women.~~

2-001.04 Coverage Rules

2-001.04A Coverage Before Enrollment: ~~Medicaid coverage for clients excluded from Managed Care participation remains on a fee-for-service basis. Clients who are excluded cannot voluntarily enroll.~~

2-001.04B Coverage During Enrollment: ~~Due to changes in a client's Medicaid eligibility and/or mandatory for managed care status, a client's enrollment in managed care may periodically change. The managed care plan(s) is/are responsible for the provision of the services covered by managed care for the client as long as s/he is identified as a member of that managed care plan.~~

2-002 ENROLLMENT

2-002.01 Purpose of Enrollment Process: Medicaid maintains responsibility for the enrollment of clients into Managed Care, through departmental and contractual arrangements. The use of an enrollment broker precludes any direct enrollment activities by the managed care plan. The role of the enrollment broker services (EBS) is the enrollment of the mandatory managed care clients into a physical health plan and assignment of a Primary Care Provider (PCP).

The enrollment broker services are intended to assist the client in understanding enrollment requirements and participation in Managed Care. To facilitate this effort, the managed care plans are required to have an understanding of the client population and the enrollment process, and to assist Medicaid and the enrollment broker in providing adequate information to the client. The managed care plans are also required to work cooperatively with Medicaid and EBS to resolve issues relating to client participation and enrollment, and to have the technological capability and resources available to interface with Medicaid's support systems.

2-002.02 Enrollment Activities in the Behavioral Health Managed Care Organization: Clients are enrolled in Behavioral Health Managed Care (behavioral health plan) by virtue of their eligibility for Medicaid in the categories listed in 482 NAC 2-001.01. There is no separate enrollment process for these services. The Behavioral Health plan shall agree to accept Medicaid clients in the order in which they are enrolled.

2-002.02A Changes in Eligibility: Changes in the client's eligibility may affect his/her managed care status, e.g., mandatory or excluded. The client receives a notice with a change in managed care coverage.

2-002.02B Effective Date of Behavioral Health Coverage: The effective date of coverage is the first day of the month of mandatory status determination and enrollment into the behavioral health plan.

The behavioral health plan is responsible for the client effective with the date of managed care coverage under Nebraska Medicaid regardless of the client's level of care at the time of enrollment. The first payment to the plan begins the first month of Behavioral Health enrollment.

2-002.02C Behavioral Health Services Before Enrollment in Nebraska Medicaid: If eligibility for Nebraska Medicaid is determined, Medicaid-coverable Behavioral Health services received before the month of Nebraska Medicaid coverage in the benefits package will be paid on a fee-for-service basis under the rules and regulations of Nebraska Medicaid in 471 NAC.

2-002.02D Client Notification of Managed Care Coverage: The client or the client's legal representative will be notified of managed care coverage and will be issued a notice of enrollment.

~~2-002.02E MCO Notification of Managed Care Coverage: The behavioral health plan will be notified of enrolled clients via an enrollment report (in the form of a data file). Medicaid electronically transmits the enrollment report to the behavioral health plan on or before the first day of each enrollment month. The enrollment report provides the behavioral health plan with ongoing information about its clients and will be used as the basis for the monthly capitation.~~

~~The behavioral health plan is responsible for providing the Behavioral Health Benefits Package to clients listed on the enrollment report generated for the month of enrollment. Any discrepancies between the client notification and the enrollment report will be reported to Medicaid for resolution. The behavioral health plan shall continue to provide and authorize services until the discrepancy is resolved.~~

~~2-002.03 Enrollment Activities in the Physical Health MCO: The client must, after receiving Managed Care information, choose a Physical Health Managed Care plan (health plan) and Primary Care Provider (PCP) (i.e. voluntary choice). Note: Family members may select different PCP and health plans but will be encouraged to choose the same health plan.~~

~~Voluntary choice and all enrollment activities must be completed and entered on the Managed Care system by the EBS within fifteen calendar days following the date of the notice sent to the client informing of the need to enroll. After fifteen calendar days, if a choice has not been made (i.e. voluntary choice), automatic assignment (see 482 NAC 2-002.06) will be completed by Medicaid. Enrollment activities may be completed via telephone call, or by mail.~~

~~The health plan must agree to accept Medicaid clients in the order in which they are enrolled through the EBS and Medicaid's auto-assignment process.~~

~~The client must have the opportunity to choose the health plan and PCP of his/her choice, to the extent possible and appropriate.~~

~~2-002.03A Reenrollment: If the client is identified as mandatory for enrollment in the Managed Care within two months of loss of Medicaid eligibility, the client will automatically be enrolled with the previous health plan effective the first of the next month possible given system cutoff. Medicaid will send the client notification of the re-enrollment.~~

~~The client is free to choose a different health plan only in these circumstances: (a) if the reenrollment is during the initial ninety (90) day period; (b) during the open enrollment period; or (c) for cause (see 482 NAC 2-003.02) by contacting the EBS and completing enrollment activities.~~

~~2-002.03B Departmental Wards/Foster Care Clients: The EBS must coordinate enrollment activities with the Child and Family Services Specialist (CFS Specialist) responsible for the case management of the ward/foster child.~~

~~2-002.03C Enrollment of an Unborn and Newborn Child: The State will pre-enroll unborns into managed care if the unborn has either a mother or sibling enrolled in managed care. Once the State is notified of a live birth, the newborn will be immediately enrolled in either the mother's MCO plan or an eligible sibling's MCO plan. The mother's plan supersedes the sibling's plan, in the event that both mother and sibling are enrolled in a managed care health plan. Enrollment changes (i.e., to a different health plan) may be made as allowed for any other client participating in the Managed Care. (See 482 NAC 2-003.02.)~~

~~2-002.03D Changes in Enrollment Status: The client will be notified by Medicaid if the client's Managed Care status changes, e.g., mandatory to excluded. Depending on the status change, the client may be required to contact the EBS and complete an enrollment, unless reenrollment rules apply (see 482 NAC 2-002.03A).~~

~~2-002.03E Follow-Up Contact by the EBS: The EBS must conduct follow-up until enrollment occurs or the client is automatically assigned to a health plan and PCP. The EBS must make reasonable efforts to contact those clients who have been automatically assigned but who have not had the benefit of an explanation of Managed Care.~~

~~Follow-up contact may include, but is not limited to, the following:~~

- ~~1. Telephone calls; and~~
- ~~2. Informational mailings.~~

~~2-002.04 Enrollment Rules: The client or the client's legal representative must complete the enrollment process. For purposes of completing the enrollment process, the following rules apply:~~

- ~~1. A friend or relative of the client, who does not have legal authority, may complete the informational portion of the enrollment process if the individual is determined to have sufficient knowledge of the client's health status;~~
- ~~2. The client or his/her legal representative (i.e., guardian, conservator, or Durable Power of Attorney (DPOA) if the DPOA has this level of authority) must make the choice of the health plan and PCP; and~~
- ~~3. The CFS Specialist must act on a Department ward's behalf. The child's foster parents must be involved in the selection of the health plan and PCP.~~

~~The health plan must not have any direct contact with the client or the client's legal representative, family or friends prior to the client becoming enrolled with the health plan, unless the contact is initiated by the EBS in an effort to facilitate the choice of health plan and PCP and as it relates to continuity of care issues.~~

~~2-002.05 Effective Date of Physical Health Managed Care Coverage: The effective date of Physical Health Managed Care coverage is the first calendar day of the month of the Managed Care auto assignment or plan selection.~~

~~Exception: Hospitalization at the time of enrollment (see 482 NAC 2-002.05D).~~

~~2-002.05A Services Before Enrollment in Physical Health Managed Care: Medicaid-coverable services received before the month of physical health managed care coverage becomes effective will be paid on a fee-for-service basis under the rules and regulations of Medicaid Title 471 NAC.~~

~~2-002.05B Notification of Managed Care Coverage: The client or the client's legal representative will be notified of Managed Care coverage.~~

~~The client's status must be verified by the medical provider through:~~

- ~~5. Medicaid's Internet Access for Enrolled Providers:
http://dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx;~~
- ~~6. The Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln 471-9580);~~
- ~~7. The Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or~~
- ~~8. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).~~

~~Through the EBS functions, and written materials and notice, the client will be kept informed of his/her right to change health plans and/or PCP.~~

~~The health plan will be notified of clients enrolled with their plan via an enrollment report (in the form of a data file). Medicaid electronically transmits the enrollment report to the health plan before the first day of each enrollment month. The enrollment report provides the plan with ongoing information about its clients and will be used as the basis for the monthly capitation payments.~~

~~If the client does not voluntarily enroll, the enrollment report will not list a Primary Care Provider. The health plan is responsible for the assignment of the PCP for clients who do not voluntarily enroll.~~

~~The health plan is responsible for providing the services in the Basic Benefits Package to clients listed on the enrollment report generated for the month of enrollment. Any discrepancies between the client notification and the enrollment report must be reported to Medicaid for resolution. The plan must continue to provide and authorize services until the discrepancy is resolved.~~

~~The Eligibility and Enrollment databases used to build the Enrollment File is the official source of validation in the case of a discrepancy. Once the cause for the discrepancy is identified, Medicaid will work cooperatively with the health plan to identify responsibility for the client's services until the cause for the discrepancy is corrected.~~

~~2-002.05C Transition Period: Within the first month of enrollment, the health plan is responsible for providing each member general information about the plan, e.g., member handbook, etc.~~

~~The health plan must work cooperatively with a client who is experiencing difficulty in transitioning to a managed care environment during the first sixty days of enrollment.~~

~~The health plan must continue all services that have been authorized by Medicaid fee-for-service or Medicaid's Peer Review Organization (PRO) prior to the client becoming enrolled in Managed Care. These services must be continued until the health plan determines that the service no longer meets the definition of medical necessity.~~

~~2-002.05D Hospitalization: When a Medicaid client is in an acute care medical or rehabilitation facility prior to the client's enrollment in managed care, Medicaid fee-for-service remains responsible for the hospitalization until the client is discharged from the facility or transferred to a lower level of care. In the event that a client is admitted as an inpatient in an acute care medical or rehabilitation facility and is assigned to a managed care health plan in the same month, the MCO is responsible for that hospitalization.~~

~~2-002.06 Automatic Assignment for the Physical Health Managed Care: All enrollment activities must be concluded within fifteen calendar days. If a choice of health plan and PCP, is not made, the client will be automatically assigned to a health plan based on criteria established by Medicaid (see 482-000-2, Auto-Assignment Procedure Guide).~~

~~Medicaid provides a report to the EBS prior to the effective date of the auto-assignment enrollment. The EBS must complete any necessary transfers if an incorrect assignment is identified.~~

~~Auto-assignment of a client is indicated on the health plan's Enrollment Report.~~

~~Medicaid's auto-assignment algorithm will attempt to maintain family members with the same health plan as much as possible.~~

~~Medicaid attempts, but does not guarantee, an equal distribution of clients to available health plans during auto-assignment.~~

2-003 PHYSICAL HEALTH MANAGED CARE DISENROLLMENT / TRANSFERS:
Disenrollment for the purposes of this section is a change in a client's enrollment from one Physical Health Managed Care plan (health plan) to another.

A transfer is a change in a client's assignment from one PCP to another PCP. A disenrollment/transfer may be made at the client's request (482 NAC 2-003.01) or at the PCP and/or health plan's request (482 NAC 2-003.03). A transfer may also be made because the client requires an Interim PCP (482 NAC 2-003.03E).

2-003.01 Client Transfer Requests: The client must contact the health plan to request a PCP transfer. A client may request a transfer from one PCP to another PCP at any time.

The health plan must assist the client in selecting a new PCP by:

1. Discussing the reasons for transfer with the client and attempting to resolve any conflicts when in the client's best interest;
2. Reviewing the client's needs to facilitate the client's choice of PCP;
3. Processing the client request; and
4. Notifying Medicaid of the PCP transfer via the PCP Transfer file. The PCP transfer will be updated on the client's Managed Care File.

If a client is requesting a PCP transfer, the health plan should carefully document the reason. Any transfer for a client under a "lock-in" provision must be completed per lock-in procedures (see 482-000-7).

2-003.02 Client Disenrollment Requests: A client may request a change from one health plan to another by contacting the EBS as follows:

6. With cause, at any time;
7. During the 90 days following the date of the client's initial enrollment with the MCO, or the date Medicaid sends the client's notice of enrollment, whichever is later;
8. Without cause once every 12 months thereafter;
9. Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the client to miss the annual disenrollment opportunity; or
10. When Medicaid imposes the Medicaid-established intermediate sanctions on the health plan.

2-003.02A Cause for Disenrollment: The following are cause for disenrollment:

1. The client moves out of the MCO designated coverage area;
2. The health plan does not, because of moral or religious objections, cover the service the client seeks;
3. The client needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the client's PCP or another provider determines that receiving the services separately would subject the client to unnecessary risk; or

3. ~~Other reasons, including but not limited to, poor quality of care, lack of access to providers experienced in dealing with the client's health care needs or lack of access to services covered under the contract.~~

~~The effective date of the plan transfer will be the first day of the month following the month of the approval determination.~~

~~2-003.02B Determination of Disenrollment for Cause: When the client disenrollment request is for cause, the EBS must complete Form MS-25, "Plan Disenrollment Client Request Form," (see 482-000-3) with the client and forward the request to Medicaid staff for a decision. Medicaid staff will take action to approve or deny the request based on the following:~~

- ~~4. Reasons cited in the request;~~
- ~~5. Information provided by the health plan at Medicaid's request; and~~
- ~~6. Any of the reasons cited in 482 NAC 2-003.02A.~~

~~The Department will take action to approve or deny the request within 60 calendar days of receipt of the request. If the request is approved, the effective date of the plan transfer will be the first day of the month following the month of the approval determination. If Medicaid staff fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.~~

~~Medicaid staff will process the disenrollment and enter the information in the Managed Care system. A notice is issued by Medicaid to the client or his/her legal representative when the disenrollment is completed. The health plan will be notified via the Enrollment Report.~~

~~The health plan may work with the EBS to resolve any issues raised by the client at the time of request for disenrollment but may not coerce or entice the client to remain with them as a member.~~

~~2-003.02C EBS Responsibilities: The EBS must also discuss with the client when processing a disenrollment request the following:~~

- ~~1. The importance of maintaining a medical home;~~
- ~~2. How the client's medical care may be affected by the transfer and what the client's responsibility is in obtaining new referrals or authorizations;~~
- ~~3. That outstanding services may require additional referrals/authorizations in order to maintain the continuation of medical care; and~~
- ~~4. That services approved or authorized by one PCP and/or health plan is no guarantee of approval/authorization of the same services with the new PCP and/or health plan.~~

~~Any disenrollment for a client under a "lock-in" provision must be completed per lock-in procedures (see 482-000-7).~~

2-003.03 Primary Care Provider (PCP) Transfer Requests: The PCP may request that the client be transferred to another PCP, based on the following situations:

1. The PCP has sufficient documentation to establish that the client's condition or illness would be better treated by another PCP;
2. The PCP has sufficient documentation to establish that the client/provider relationship is not mutually acceptable, e.g., the client is uncooperative, disruptive, does not follow medical treatment, does not keep appointments, etc.;
3. The individual provider retired, left the practice, died, etc.; or
4. Travel distance substantially limits the client's ability to follow through the PCP services/referrals.

The PCP must maintain responsibility for providing the services in the Basic Benefits Package to the client until a transfer is completed.

The health plan must assist its PCPs and specialists in their efforts to provide reasonable accommodations, e.g., provide additional funding and support to obtain the services of consultative physicians, etc., for clients with special needs, e.g., HIV/AIDS.

2-003.03A Procedure for PCP Transfer Requests: The following procedure applies when a PCP requests a transfer:

1. The PCP must contact the health plan for which the client is enrolled and provide documentation of the reason(s) for the transfer. The health plan is responsible for investigating and documenting the reason for the request. Where possible, the health plan must provide the PCP with assistance to try to maintain the medical home;
2. The health plan must review the documentation and conduct any additional inquiry to clearly establish the reason(s) for transfer;
3. The health plan must submit the request to Medicaid for approval within ten (10) working days of the request;
4. If a PCP transfer is approved, the health plan will contact the client and assist the client in choosing a new PCP;
5. If the client does not select a PCP within fifteen (15) calendar days after the decision, the health plan will automatically assign a PCP.
6. The health plan must enter the approved transfer of PCP on the PCP file for the information to be reflected in the Managed Care system;

The criteria for terminating a Medicaid client from a practice must not be more restrictive than the PCP's general office policy regarding terminations for non-Medicaid clients.

The health plan must provide documentation to Medicaid prior to submitting the PCP transfer request that attempts were made to resolve the PCP-client issues (see 482-000-3 Health Plan Disenrollment/Primary Care Provider (PCP) Transfer Procedure Guide).

2-003.03B Interim PCP Assignment: The health plan will be responsible for assigning an Interim PCP in the following situations:

1. The PCP has terminated his/her participation with the health plan, e.g., PCP retires, leaves practice, dies, no longer participates in managed care;
2. The PCP is still participating with the health plan but is not participating at a specific location and the client requests a new PCP (i.e., change in location only); or
3. A PCP/health plan initiated transfer has been approved (see 482 NAC 2-003.03A) but the client does not select a new PCP.

The health plan must immediately notify the client, by mail or by telephone, that the client is being temporarily assigned to another PCP within the same health plan and that the new PCP will be responsible for meeting the client's health care needs until a transfer can be completed.

2-003.03B1 Client Notification: The notification sent to client by the health plan must include the following information:

1. Client name, address and Medicaid number;
2. Reason for the change;
3. Name, address and telephone number of the new PCP;
4. Notification that the client has fifteen calendar days to contact the health plan if s/he wishes to change the temporary PCP assignment. If the client does not contact the health plan to effect a change, the temporary PCP will automatically become permanent; and
5. Information on how to contact the health plan.

2-003.03B2 (Reserved)

2-003.04 Physical Health Plan Disenrollment Requests: The Physical Health Managed Care plan (health plan) may request that the client be disenrolled from the plan and re-enrolled in another plan, based on the following situations:

1. The health plan has sufficient documentation to establish that the client's condition or illness would be better treated by another health plan; or
2. The health plan has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of services by the client.

The health plan must provide documentation showing attempts were made to resolve the reason for the disenrollment request through contact with the client or his/her legal representative, the PCP, or other appropriate sources.

The health plan must maintain responsibility for providing the services in the Basic Benefits Package to the client until a disenrollment is completed.

The health plan is prohibited from requesting disenrollment because of a change in the client's health status or because of the client's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs.

2-003.04A Procedure for Physical Health Managed Care Plan Disenrollment Requests: The following procedure applies when the health plan requests a client disenrollment:

1. The health plan for which the client is enrolled must provide documentation to Medicaid which clearly establishes the reason(s) for the disenrollment request;
2. The health plan must submit the request to Medicaid via Form NHC-5 (see 482-000-3);
3. The health plan must send notification of the disenrollment request to the client at the same time the request is made to Medicaid. The client notification must include the client's grievance and appeal rights;
4. The client, PCP and health plan are notified of the approval or denial of the disenrollment request and information will be made available electronically.
5. If approved, the disenrollment will become effective the first day of the following month, given system cut-off.

2-003.05 Hospitalization During Transfer: When a Managed Care client is hospitalized as an inpatient for acute or rehabilitation services on the first day of the month a transfer to another physical health plan is effective, the physical health plan which admitted the client to the hospital is responsible for the client (i.e., hospitalization and the related services in the Basic Benefits Package) until an appropriate discharge from the hospital or for sixty days, whichever is earlier. The physical health plan the client is transferring to is responsible for the client (i.e., hospitalization and the related services in the Basic Benefits Package) beginning the day of discharge or on the 61st day of hospitalization following the transfer, whichever is earlier. The physical health plan must work cooperatively with the EBS and Medicaid to coordinate the client's transfer.

2-004 WAIVER OF ENROLLMENT: Waiver of enrollment is the determination that a client is not mandatory for physical health and/or behavioral health managed care.

2-004.01 Waiver of Enrollment Due to Eligibility Changes: Waiver of enrollment will occur in the following situations:

1. The client's Medicaid case is closed or suspended; or
2. The client is no longer mandatory for Managed Care (see 482 NAC 2-001.02 and 2-001.03).

Medicaid will notify the client and managed care plans of the waiver of enrollment. Waiver of enrollment is prospective and is effective the first of the next month possible, given system cutoff.

~~2-004.01A Hospitalization-Related Waivers of Enrollment: Waiver of enrollment from Managed Care will occur automatically in the following situations due to a change in mandatory status for Managed Care. If the client is receiving inpatient hospital services at the time of waiver, the following rules apply:~~

- ~~1. Waiver of enrollment due to loss of Medicaid eligibility: When a Managed Care client is receiving inpatient acute or rehabilitation hospital services on the first day of a month that the client is no longer eligible for Medicaid benefits, the health plan is not responsible for services effective the first day of the month the client is no longer Medicaid eligible.~~
- ~~2. Waiver of enrollment due to Medicare eligibility: When a Managed Care client is receiving inpatient acute or rehabilitation hospital services on the first day of the month that the client's Medicare coverage has been entered on the Medicaid eligibility system and is effective, the health plan is no longer responsible for the hospitalization effective with the client's waiver of enrollment from Managed Care. The health plan is responsible for coordinating benefits with Medicare and is responsible for all applicable coinsurance/copayments until the client's disenrollment from Managed Care is effective.~~
- ~~3. Waiver of enrollment due to transplant: All services provided to the Managed Care client from the day of the transplant or the day that preparatory treatment (chemotherapy or radiation therapy) for bone marrow/stem cell transplants begins, the health plan is no longer responsible for the hospitalization and the provider will be reimbursed on a fee-for-service basis by Medicaid. The transplant procedure must be prior authorized by Medicaid staff. The health plan must notify Medicaid of the date of the transplant. Medicaid will initiate the waiver of enrollment of the client from Managed Care. The Medicaid eligibility system will reflect the client's waiver of enrollment from Managed Care the first month possible, given system cutoff.~~
- ~~4. Waiver of enrollment due to Level of Care Change: When a Managed Care client is receiving inpatient acute or rehabilitation hospital services and the client's enrollment from Managed Care is waived due to a level of care change, e.g., the level of care the client requires changes from acute care services to custodial care, the health plan is responsible for the hospitalization and all services provided in the Basic Benefits Package until waiver of enrollment occurs.~~
- ~~5. Waiver of enrollment due to eligibility category change: When Managed Care client is receiving inpatient for acute medical/surgical or rehabilitation hospital services and has enrollment waived from Managed Care due to an eligibility status change, e.g., the client is no longer in a mandatory group for Managed Care participation, the health plan is responsible for the hospitalization and services provided in the Basic Benefits Package until waiver of enrollment occurs.~~

2-004.02 (Reserved)

2-004.03 Admission to Nursing Facility Care: Admission to a nursing facility may affect the client's enrollment in Physical Health Managed Care. The following rules apply:

1. When a Managed Care client is admitted to a nursing facility, the physical health plan must determine the level of care the client requires—skilled/rehabilitative or custodial/maintenance—using Medicare's definition of skilled care.
When the level of care the client requires is skilled/rehabilitative, the physical health plan is responsible for payment of services for the client while receiving skilled level of care services.
2. When the client is admitted to a nursing facility for custodial care (i.e., long term care), the client will be waived from enrollment. Medicaid fee-for-service will assume financial responsibility for the facility charges beginning on the date the custodial level of care determination is made. Payment for all services included in the Basic Benefits Package will be the responsibility of the health plan until the waiver of enrollment from Managed Care is effective.
3. Waiver of enrollment from Managed Care will be effective the first of the next month possible, given system cutoff.
4. When the client is admitted to a nursing facility for custodial care and the client's PCP does not see patients at the facility, the health plan must work cooperatively with the client and the nursing facility to locate a PCP for the client. The health plan must make arrangements to ensure reimbursement of PCP services provided by the client's nursing facility physician, for referrals, and for all services included in the Basic Benefits Package until the client's waiver of enrollment from Physical Health Managed Care is effective.

For purposes of Physical Health Managed Care, skilled nursing services are those nursing facility services provided to eligible clients which are skilled/rehabilitative in nature as defined by Medicare and the nursing facility admission is expected to be short term. Custodial services are those nursing facility services as defined in 471 NAC and the nursing facility admission is expected to be of long term or permanent duration.

(See 482-000-6, Nursing Facility Procedure Guide.)